LOS ANGELES COUNTY COMMISSION FOR CHILDREN AND FAMILIES

Dana E. Blackwell
Executive Director

APPROVED MINUTES

The General Meeting of the Commission for Children and Families was held on Monday, **August 7, 2006**, in room 739 of the Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles. **Please note that these minutes are intended as a summary and not as a verbatim transcription of events at this meeting.**

COMMISSIONERS PRESENT (Quorum Established)
Helen A. Kleinberg
Ann E. Franzen
Susan F. Friedman
Daisy Ma
Dr. La-Doris McClaney
Rev. Cecil L. Murray
Sandra Rudnick
Adelina Sorkin
Dr. Harriette F. Williams

COMMISSIONERS ABSENT (Excused/Unexcused)
Carol O. Biondi
Patricia Curry
Hon. Joyce Fahey
Wendy L. Ramallo
Stacey F. Winkler

YOUTH REPRESENTATIVE
Jason Anderson

APPROVAL OF THE AGENDA
The agenda for the August 7, 2006, meeting was unanimously approved.

APPROVAL OF MINUTES
The minutes of the July 17, 2006, general meeting were unanimously approved.

CHAIR'S REPORT

- Chair Kleinberg read an original poem in honor of outgoing executive director Dana Blackwell; a framed gift from the Commission will also be forthcoming.

- Helen Berberian, the Department of Children and Family Services liaison to the Commission, is moving to Supervisor Michael Antonovich's office, and Chair Kleinberg presented a children's painting to her in appreciation of her service. Ms. Berberian thanked Commission volunteers for their ongoing passionate commitment to children, saying that she had learned much and looks forward to continuing to work with the Commission in her new position.

- The Commission is working with the Executive Office to retain interim help following Ms. Blackwell's departure on August 15, and to hire a new executive director. Commissioners wishing to participate on the personnel group were asked to contact Chair Kleinberg or Vice Chair Rudnick. The possible restructuring of Commission meetings is also being considered and will be explored at the fall retreat; anyone interested in serving on that committee was asked to contact Commissioner Ma.

- Chair Kleinberg thanked Ms. Blackwell for representing the Commission at the various meetings she regularly attends (to be reported on later this morning). Anyone interested in attending these groups in her place was encouraged to call the office.

- Departmental plans for the Title IV-E waiver funds are now being discussed at community meetings arranged by DCFS regional offices, and Commissioners were urged to attend meetings in their areas.

DIRECTOR'S REPORT

Acting director Joan Smith made it clear that her goal for the department is to continue moving toward the outcomes established by former director David Sanders. To assume the financial duties she had retained upon her appointment as deputy director, the Chief Administrative Office has loaned DCFS the services of Claudine Crank, who will assist in the finance area for three months.

- The Permanency Planning Partners (P3) program is operational in all regional offices and has served 804 youth as of the end of June. Of these, 83 were paired with mentors and 260 have a permanency plan in place—66 are being reunified with their families, 72 are being adopted, and 122 are entering into legal guardianships. Many of the remaining youth continue in long-term foster care.

- After a five-office pilot, concurrent planning is being rolled out to additional sites. Hawthorne became operational on May 30, Pomona on June 12, West Los Angeles on July 5, and Lancaster on July 31. Santa Clarita is scheduled for August 16, and Pasadena will follow, with the goal of bringing concurrent planning to all offices by March of 2007.

Commissioner Williams asked about the 120 percent staffing goal promised for point of engagement, and Ms. Smith said that the department meets that goal on average, although staffing issues in specific offices need resolution. The allocation notification for new state monies to reduce caseloads was received last Friday; the department is developing a plan for the use of those funds that it will present to the Board of Supervisors in early September.

- Of the 301 positions allocated to the department in April, all but three have been hired (one in the human resources section, and two clerical positions). Of the 211 allocated on July 1, 89 positions are still in process. All social worker positions have been hired, and those brought aboard in April are on the job, since the department's training academies are being held more often than usual to accommodate new employees.

- Ms. Smith reviewed the one-page document in Commission packets showing the relationships between the already established Commission work groups and the Title IV-E target outcomes. Los Angeles County's letter of intent to the state regarding the waiver was submitted on July 21, and three other counties—Orange, Alameda, and Humboldt—have also expressed interest. The state is still considering what funding will look like, and counties are expected to work with the County Welfare Directors Association to develop a memorandum of understanding for participation. Waiver implementation is scheduled to begin on January 1, 2007, and much work remains to be done prior to that time. Counties were originally expected to submit their plans by September 8, a deadline now extended to September 29. In Los Angeles County, this means that the plan must be filed for the Board of Supervisors agenda by September 7, to be heard on September 19.

  Local planning efforts are underway in all regional offices, and that input is due to the department by August 11. A working group of lead managers will sort through those submissions and present a coordinated package to the four existing work groups. (The Commission office has dates for those work group meetings, which are scheduled between August 14 and 25.) A joint community/county meeting will take place on August 28, and Commissioners were urged to attend. Staff will pull together the final plan between then and Labor Day. Ms. Smith emphasized that the plan approved by the Board in September would not necessarily set procedures in stone for the next five years, but will be an ongoing process—an opportunity to test strategies and direct resources to options that work, monitoring and adjusting as necessary.

  Although the literature indicates that visitation is a vitally important component to reunification, Vice Chair Sorkin noted that visitation was not mentioned in the outcomes/work group document. Ms. Smith said that strategies proposed by the visitation group would be passed on to the reunification and permanency work groups, and Chair Kleinberg confirmed that the document prepared by the visitation group had been sent to the reunification work group.

PREVENTION COMMITTEE
Vice Chair Rudnick reported that a small group met last week to consider two prevention plans to be merged and presented to the Board of Supervisors, and adopted the basic principles of the plan for which the Commission and DCFS laid the groundwork. Further details on implementation and financing will be developed, and committee members will attend waiver planning meetings to make sure prevention issues are addressed there. The detailed prevention plan will be presented to the Commission at a later date.

CHILD FATALITY PROTOCOL
Commissioner Friedman and Ms. Blackwell met with the department and County Counsel to discuss the appropriateness and feasibility of Commission involvement in child death reviews. In general, no objections were voiced to Commission participation except with regard to analyzing employee actions that may have led to the fatality; however, the quick timeframe for reviews (within 24 to 72 hours) could present some challenges. Commissioner Friedman recommended involvement on at least an informal basis, with notification regarding every death and access to autopsy reports.

The Commission does not sit on the death review teams managed by ICAN (the Inter-Agency Council on Child Abuse and Neglect), and has no wish to duplicate those efforts, but very much wants to identify potential systemic issues when a fatality or serious injury occurs to a child in care. Commissioner Ma recommended discussing possible protocols at the Commission retreat rather than voting on Commission involvement today. **Commissioner Friedman moved that the Commission continue the process of determining what its involvement in child death reviews might be. Commissioner Murray seconded the motion, and it was unanimously approved.**

COURT PERMANENCY COMMITTEE
The Committee is co-chaired by the court and the department to examine ways that they can work together to decrease the number of children with plans of long term foster care. The first phase of this committee's work was to develop a departmental *F.Y.I.* and a permanency handbook, both of which have been distributed widely. The group is now developing ways for the court and the department to work together to outline when legal guardianship is appropriate for relatives and nonrelative extended family members. A subcommittee will meet in September on the latter issue, and will bring recommendations to the larger group.

RUNAWAY TASK FORCE
Approximately 100 children a month leave placement without permission, and this task force—made up of representatives from the Children's Law Center, law enforcement, group home providers, the Association of Community Human Service Agencies, and others—is looking at ways to decrease that number. One issue is the responsibility of the placement to follow up on runaways with law enforcement, something that families do as a matter of course, but that often doesn't happen for foster children. The task force has also interviewed some youth in SPA 4 regarding their runaway behavior, how many had witnessed or been involved in violent activity while gone, how many had used drugs, and

so on. Many youth leave their facilities to visit friends or family over the weekend, for instance, and return voluntarily, but the agency must still report the child missing.

SUBSTANCE ABUSE PROTOCOL FOR DEPENDENT MINORS
DCFS and the court co-chair this group, which looks at ways to assist dependent youth with substance abuse issues. (It is not associated with the drug court, which is for parents.) Its last meeting examined assessment tools to identify youth substance abuse, and Childrens Hospital Los Angeles representatives presented that agency's model. Vice Chair Sorkin volunteered to attend.

RESIDENTIALLY BASED SERVICES WORK GROUP
This group, formerly known as the Group Home Services Work Group, was formed to look at how group homes are used as part of the continuum of treatment care to help children move to permanency. Its membership consists primarily of the county's larger group homes, rather than smaller group homes in the communities from which children are being removed. As the trend moves away from residential care, the numbers of those homes is expected to decrease.

The work group is currently looking at Title IV-E waiver recommendations and at research done by John Lyons in Illinois on how different populations fare in different types of placement settings. Lisa Parrish will present those findings to the Commission in September. The group meets on the third Thursday of every month.

MEDICAL HUBS
Dr. Charles Sophy and Ricky Tadeo reviewed a matrix of information and operational details for the medical hubs as of July 20, jointly prepared by DCFS and the Department of Health Services. The visit statistics covered only July 1 through July 10; the particulars for all of July will be available on August 20.

The six hubs are at different stages of development, but all are able to provide initial examinations (routine upon a child's entering the system) and forensic examinations (when there is evidence of criminal abuse), most within the required timeframes. Examinations include a medical assessment and an age-appropriate mental health screening tool, one for children five and under, and another for older children. Several populations are mandated to visit the hubs: any newly detained child, children injured in care, those needing a second opinion, and any child with a medical plan that needs redirection. Social workers may also request that a child visit a hub prior to detainment. The medical directors of the hubs meet monthly to discuss consistency, screening tools, and developmental issues; the goal is to provide 'one-stop shopping' for children and caregivers.

In general, social workers, parents, and caregivers transport children to the hub facilities, but a pilot transportation program is being implemented in the East San Gabriel Valley and other outlying areas to determine the need for satellite hubs. Medical staff are permanently assigned to the hub clinics, and are selected for their training and expertise in dealing with children in trauma. (Recruitment at the High Desert hub, where several positions are open, continues to be a challenge because of its location.) It is up to each hub

whether to retain a child as a continuing patient, or to connect the family to a community provider. The goal is for the child to consistently see the same doctor as much as possible, and for information to be readily available to other hubs or care providers. Now that the hubs are operational, they are expected within the next couple of months to pull in collaborative groups of board-certified CHDP providers from the surrounding community to function as HMO-like support groups. In addition, public health nurses are being co-located at the DCFS regional offices that feed into the hubs to help with waiting-list issues and troubleshooting.

Dr. Sophy explained the chain psychotropic medication recommendations go through, since the only control DCFS has over them is to work with the courts and the Department of Mental Health. All prescription requests from community doctors are sent to the court. Upon approval, the court forwards the request to DCFS's D rate unit, which contacts the biological parent for an okay. With the parent's consent, the request returns to the court, which makes a final decision. The department tracks all requests to the D rate unit in terms of medication, types of children, diagnoses, doctors, and doctors' certifications. It is also developing a database of doctors, and wants to put together a team that involves a nurse practitioner or public health nurse to work with the court.

Caregivers often complain that they are given little or no information about the mental health status of children placed with them, and Chair Kleinberg asked what the hubs have learned in that regard. If a newly detained child is traumatized, is that the best time to perform a mental health assessment? DMH's Sandra Thomas explained that the hubs use a standardized mental health screening developed by the California Institute of Mental Health, which is designed to be administered by a non–mental health professional. If there is a 'positive hit' on that assessment, the child is referred to a mental health provider attached to the hub for crisis intervention if necessary, and an in-depth evaluation. Otherwise, the team decision-making process involves co-located DMH staff for an on-site assessment or an immediate link to a community provider. The results of the screening tool are always shared with the child's social worker, and certain 'red flags' mean that the hub will not release the child without crisis intervention. Detained children automatically go through the Multidisciplinary Assessment Team (MAT) process, and the MAT coordinator is usually the first to contact the caregiver. The MAT process, however, can take up to 30 days, and Chair Kleinberg reported that caregivers are often given no information during that time. Dr. Laura Andrade said that the MAT process should begin within 72 hours of detention, and crisis intervention services are available and can be immediately provided.

Issues often come up, particularly with older youth, around being labeled with a mental health diagnosis when they may simply be traumatized by what's going on in their lives and acting out against very appropriate feelings. Many times youth see medication as taking them "down the road to being a mental case" or as just sedating them for others' convenience. Because a diagnosis is required to support funding, Sandra Thomas said, mental health professionals must provide one, but staff should also be trained to educate youth more thoroughly and sensitively about their diagnoses and prescribed medications.

Dr. Astrid Heger opened the VIP (Violence Intervention Program) Forensic Medical Clinic two years ago to create 24-hour-a-day crisis care for victims of child abuse and sexual assault. Examinations are done by pediatricians and nurse practitioners, with up-front mental health triage. By contrast, the Community-Based Assessment and Treatment Center (CATC) clinic is meant to be a medical and mental health home for children in foster care, administering four-hour medical and mental health screenings and assessments. Dr. Heger is hoping to use technology to connect the clinic electronically with the medical hubs, just as nurse practitioners are linked by tele-medicine to the hub at High Desert Medical Center.

Dr. Heger is concerned about overmedication within the foster-care population, and the fact that many children have medical problems that are never diagnosed. In addition, she is finding an increasing number of children exposed to alcohol *in utero*, which can cause a wealth of medical and mental health problems. The medical hubs do refer children with developmental delays to Regional Centers, but even when they are accepted there, fetal alcohol spectrum disorder often "flies under the radar" of Regional Centers. Dr. Heger hopes to open a specialized clinic for foster children with these issues by September 1.

When Dr. Heger began her work in 1984, her clinic was the only one in Los Angeles County that performed examinations for sexual assaults on children. Now, every child for whom that may be an issue gets that assessment, since a huge overlap exists between physical and sexual abuse, and providers taking a simple history may not ask the right questions. At present, Dr. Heger's clinic sees between 70 and 80 acute sexual assaults per month, a good portion of them children. A pediatrician who is a child development specialist is on staff half-time, and all children aged five and under—who make up a quarter of the children in DCFS care—receive age-appropriate exams.

When children die in care, Chair Kleinberg commented, autopsies sometimes show evidence of beatings and bruises that no one knew about. How can this be prevented, beyond the CHDP examinations required once a year? Dr. Heger's view is that doctors in general care often don't pay close attention to these signs, and the hubs are an attempt to create an environment that can document these injuries. The goal is for the child to always go to the same facility with the same pediatrician, and for the medical hub system to ultimately move beyond the foster-care population into family preservation and family reunification. A facility being built adjacent to the VIP LAC+USC hub will include space to co-locate emergency response workers during off-hours, as well as a family assessment center.

MULTIDISCIPLINARY ASSESSMENT TEAMS (MATs)

Laura Andrade briefly reviewed the concept of the Multidisciplinary Assessment Teams (MATs), a collaboration between DCFS, DMH, and private service providers that is an attempt to get a snapshot of the child and family and link them to needed resources right away. In the detention report, the emergency worker asks the court to authorize the MAT assessment, and the judge issues a minute order instructing an assessment within 72 hours. The MAT coordinator in each DCFS regional office obtains information on the family from the emergency worker and forwards it to the provider. (Both DCFS and

DMH have MAT coordinators who follow the same process and meet regularly with each other to locate providers and make referrals.) The provider then has 30 to 45 days to complete the assessment and pass it to the MAT coordinator. He or she gives it to the child's social worker, who submits it to the court where it informs case planning. MAT workers also evaluate how the recommended services are helping the child and family.

A 2004 pilot of the program was done in the Wateridge and Pasadena offices with 22 families and 36 children. Outcome statistics exceeded DCFS permanency goals by 10 percent, thus proving the program's worth. After a Request for Interest was issued by DMH in August 2003 that yielded 22 responses, the MAT process was rolled out in SPA 6 (starting June 2005) and SPA 3 (October 2005). Staff is now on board for a MAT component in Compton, with training scheduled for August 23 and implementation hoped for by mid-September or early October. SPAs 1 and 7 are next in line, with trainings in September and October, respectively, to roll out in October and November.

Capacity is an issue, and SPA 6 in particular is struggling to meet the referral need. Overall, close to 500 MAT assessments have been initiated since the inception of the program, with over 300 being completed. Qualitative reviews show that the majority of parents and families are engaged in the MAT process and receive information that helps them.

Dr. Barbara Stroud from the Los Angeles Child Guidance Clinic, a MAT provider agency, explained the details of what MAT providers do, which includes interviewing family members, reviewing medical and education records, visiting the child's day care setting, making referrals to Regional Centers, and doing a lot of "hand-holding" to make sure that caregivers are successfully linked with services. Workers are also involved in team decision-making meetings to share information that can change the shape of the child's case plan. The 30- to 45-day timeframe for the MAT process is admittedly longer than ideal, but is dictated by a number of factors, among them the time it takes to arrange a minute order, schedule a team meeting, and contact everyone who needs to be involved. Looking at available dates before the report draft is completed is advisable.

Betsy Pfromm, Child Guidance's executive director, shared her enthusiasm for the MAT model and for the collaborative work being done between departments. Financially, however, some concerns arise because not everything within the MAT process can be billed. In 1993, Medicaid (known in California as Medi-Cal) altered some of its claiming options, not foreseeing the rise of interagency models such as systems of care, wraparound, and MAT. Some non-Medicaid monies have historically been bundled with both wraparound and systems of care (at least up until two years ago), but not so with MAT. For example, if an infant goes through the assessment process and receives a deferred diagnosis, the child's Medicaid chart is closed and Medicaid will not pay for further MAT meetings to coordinate needed care.

If billing is not clear-cut, clinics are running risks in unprecedented ways, possibly triggering onerous Federal and state audits whose 'accountability measures' can order the take-back of dollars after services have already been provided. (Following one such audit in Iowa, the take-back totaled 25 percent of the children's mental health services budget.)

The Senate Finance Committee seems to understand this issue and has inserted language to address it in a budget trailer bill, and asked a statistician to examine the methodology. It will be October before the results of those efforts are known.

OTHER BUSINESS

Commissioner Williams recently attended a Wateridge advisory meeting that discussed at length the issue of provider capacity in SPA 6. From what she heard, agencies who serve the public there are not getting the help they need from DMH to qualify as providers for that area. The director of S.H.I.E.L.D.S. for Families, the SPA's largest provider organization, reportedly said that its capacity is being reached with point of engagement and other prevention activities, and it can't keep up with the demand. Other agencies—those the community trusts, that have been in the SPA for years—would like to be involved, but apparently cannot get certified by the state through DMH. Commissioner Williams asked that the Commission consider this issue at another time.

PUBLIC COMMENT

There was no public comment.

MEETING ADJOURNED